Current Perspective

Whither Narrow Networks?

In the past year, we have seen many examples of physicians, ambulatory surgery centers, and hospitals being decredentialed, sometimes in midcontract, for seemingly inexplicable reasons. The result is a health care product with fewer providers—or a narrowed network. This process—in particular, its opacity—has been roundly criticized by providers, Congress, and consumer groups as being unfair and sometimes illegal. It breaks long-standing physician-patient relationships, disrupts care processes, and causes significant financial problems for individual practices and logistical hardships for individual patients. Such changes have drawn particular attention in conjunction with Medicare Advantage plans, which have enrolled more than 30 percent of Medicare-eligible patients.

Academy members frequently ask me the following questions: Why are they doing this? Am I likely to be economically credentialed? Is Congress going to change this? What can I do when I'm cut from a network?

The principal driver toward narrow networks is, unsurprisingly, money that insurance companies hope to save by eliminating physicians identified as higher cost. Health plans generally expect this to result in costs that are 5 percent to 15 percent lower than traditional plans. Some networks don't eliminate physicians from their networks entirely, but will relegate them to a higher tier that requires higher patient copayments. At the same time, the plans insist that quality comes first when selecting physicians for their narrow (or tiered) networks.

Virtually every physician in America who participates in commercial contracts is being economically tiered. And even though the software that health plans now use for this purpose is more sophisticated than earlier versions, there are still flaws.

Is this narrowing process likely to change? Will pressure from hospitals, physicians, and patients reverse the trend? Not really. Commercial networks that can keep costs low will have the greatest success in the marketplace. Eliminating physicians (quality—however measured—being equal) who are associated with higher costs per encounter type is something employers can't do, but commercial plans can. Any Congressional or regulatory pressure on payers to open wide their networks to less "cost-effective" or "lower-value" physicians will be viewed as driving up costs. Individual plans will add physicians and hospitals where they've cut too deeply into their network, but this will be driven by local factors, not by sweeping federal mandates.

The Academy and other physician organizations have called for CMS to examine network adequacy and economic credentialing processes. In response, CMS has changed some Medicare Advantage rules that govern termination and notification processes. More changes will come, but they are more likely to deal with specific processes than with the trend itself.

So what steps can an individual physician take? Next month's *EyeNet* will have specific recommendations. One simple step is to promptly file an appeal. The Academy's Washington office has had considerable success in working with members to get these adverse decisions overturned. The better risk-adjusted data you have on your practice's cost and processes and outcomes of care, the more powerful your case. Whether you obtain it through the IRIS Registry or a sophisticated analysis of your own EHR data, the information is crucial in rebutting allegations about quality or value.

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